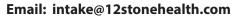
## **TwelveStone Health Partners**

Fax Referral To: (615) 278-3355

**Direct Phone: (844) 893-0012** 





TEPEZZA ORDER FORM							
Date:		ICD-10 Code:				Therapy Status	
Patient Name:		Allergies:			☐ New Start		
Date of Birth:		Weight:Ibs O	R	kg	9	Continuing Therapy: Last Dose:	
PROVIDER INFORMATION							
Ordering Provider: F					k:		
Provider NPI:			Provi	Provider Address:			
Provider Phone:							
MEDICATION ORDER							
<ul> <li>✓ Administer Tepezza 10mg/kg IV x one dose per protocol.</li> <li>✓ Administer Tepezza 20mg/kg IV x 7 doses every three weeks, starting three weeks after initial 10mg/kg dose per protocol.</li> <li>✓ First two doses to be administered over 90 minutes. If well tolerated, subsequent doses may be administered over 60 minutes.</li> <li>✓ Baseline hearing assessment has been performed by prescriber and will be evaluated periodically by</li> </ul>		ered ✓	Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:  ✓ Hgb A1C within the past six months (if patient is diabetic). If patient is not diabetic, baseline Hgb A1C will be drawn with first infusion  ✓ Baseline blood glucose within the past 60 days for non-diabetic patients				
prescriber during and after completion of treatment.							
<u>Oral</u> PRE-MEDICATIONS  IV							
□ Acetaminophen:325mg500mg650mg         □ Loratadine: 10mg         □ Cetirizine: 10mg         □ Diphenhydramine:50mg         □ Famotidine:20mg40mg         □ Ibuprofen:200mg			g <u> </u>		Diphe Famo Methy Hydro Ondar	enhydramine:25mg50mg  otidine:20mg40mg  lylprednisolone: 125mg  ocortisone: 100mg  ansetron:4mg8mg  or:	
LAB ORDERS (please indicate any labs to be drawn and frequency)			ncy)		OTH	HER REQUIRED DOCUMENTATION	N
**Surveillance lab ordering and monitoring is the responsibility of the prescriber**  By signing below, I certify that the above therapy is medi By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as m to payors with respect to this patient and prescription order. This enrollment Dispense as Written:			to 8  H P W N R S medically ve as my desinollment form	y designated agent in submitting prior authorizations and other clinically required information			
Prescriber Signature Date		Date	 Pre	Prescriber Signature Date			